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Hospital

August 20, 2018

Susan Newton, R.N, B.S
Supervising Nurse Consultant
Facility Licensing and Investigations Section
410 Capital Avenue, P.O. Box 340308
Hartford, CT 06134-0308

RE: Lawrence + Memorial Hospital Letter of Violation, August 6, 2018

Dear Ms. Newton,

Please find attached Lawrence + Memorial Hospital's response to your letter dated August 6, 2018 containing plans of correction and response for the violations set forth in the letter.

If you need additional information, please contact me at Marguerite.Langlais@LMHOSP.ORG or by phone at 860-442-0711 Ext. 3402.

Sincerely,

Marguerite Langlais

Marguerite Langlais, RN, BSN, MS-PSL, CPHQ
Manager, Accreditation and Regulatory Affairs

ML:jd:attachment

CC: Patrick Green
Denise Fiore
Oliver Mayorga, MD
Victoria Dahl Vickers

365 Montauk Avenue
New London, CT 063.20
Phone: 860-442-0711 Ext. 3402

lmhospital.org

FACILITY: Lawrence & Memorial Hospital

DATES OF VISIT: May 30 and July 19, 2018

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical Records (3), and/or (e) Nursing Service (1) and/or (i) General (6).

1. Based on a review of clinical records, interview and policy review, for one of three patients reviewed for care and services, (Patient #1), the facility failed to ensure the patient had nothing by mouth prior to having a colonoscopy resulting in aspiration pneumonia. The finding includes the following:
   a. Patient #1 presented to the facility on 11/9/17 for an outpatient colonoscopy. Review of the clinical record identified that the patient had a history laparoscopic right colectomy on 8/14/13, for colon polyps, gastroesophageal reflux disease (GERD), developmental disability, asthma, and obsessive compulsive disorder.

      Review of the patient's nothing by mouth status (NPO) status noted that the last liquid consumed was on 11/8/17 at 10 PM and last solid food consumption was on 11/7/17 at 9:35 AM. Review of the Anesthesiologist's pre-operative note dated 11/9/17 at 10:07 AM identified that the patient's nothing by mouth status (NPO) was reviewed, the patient's breath sounds were clear to auscultation with an anesthesia plan for monitored anesthesia care (MAC).

      Review of the record noted that anesthesia started at 11:49 AM, the procedure started at 11:51 AM, and during the procedure the patient aspirated and vomited dark brown liquid. Review of the colonoscopy note by MD #1 indicated the scope was up to the splenic flexure when the patient began to vomit large amounts of dark material. Shortly after vomiting the patient's oxygen saturation went down, the scope was immediately removed and anesthesia took over management of the hypoxemia and probable aspiration. There was a brief period of time when there was no obvious pulse and chest compressions were performed. Shortly after intubation, the patient had a good pulse and oxygen saturations, was transferred to the emergency room and admitted to the intensive care unit.

      Review of the discharge summary dated 11/28/17 identified that during the initiation of the procedure (colonoscopy) an episode of aspiration with significant pneumonia, acute respiratory distress, mechanical ventilation with a prolonged ICU stay, maintained on a ventilator. The patient remained frail and unstable, developed acute renal failure with hemodialysis recommended. The patient's guardian decided against hemodialysis and the patient was terminally extubated and expired on 11/28/17.

      Interview with RN #1 on 7/19/18 at 11:20 AM stated that on 11/9/17 the patient was brought to the procedure room and while in the procedure room waiting for the physician the patient repeatedly kept asking for something to drink. RN #1 stated that at some point

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CRNA #1 left the room and returned with a cup of coffee and gave it to the patient who drank approximately 4 ounces of fluid. RN #1 stated that he questioned the CRNA and she indicated that it was not a problem. RN #1 stated that shortly after the procedure was started the patient started to retch and subsequently vomited, a large amount of brown coffee ground like fluid. RN #1 stated that 200 cubic centimeters (cc) was suctioned from the patient. The record lacked documentation to reflect that the patient was provided fluids prior to the procedure, including the amount and/or type of fluids.

Interview with MD #4 (Anesthesiologist) on 7/19/18 at 12:30 PM stated it is not the standard of care to give a patient fluids prior to the procedure. Interview with MD #1 on 7/19/18 at 1:15 PM stated if he was aware that the patient had oral fluids prior to the procedure on 11/9/17, he would have cancelled the procedure. The Certified Registered Nurse Anesthetist (CRNA) that provided the fluids to the patient on 11/9/17 was no longer employed by the hospital, therefore, an interview was not conducted.

Review of the Anesthesia Practice Guidelines indicated that minimum fasting period for patients undergoing an elective procedure is two hours.

DPH Citation	Measure to Prevent Reoccurrence	Completion Date
1a.	1. A review of current practice parameters for pre-operative fasting was completed by Anesthesia services. 2. Immediate education related to practice parameters for pre-operative fasting was provided to the nursing Peri-Operative team. This education was completed via Peri-Operative safety huddles during the weeks of November 9, 2017 through November 20, 2017. 3. Education on practice parameter for pre-operative fasting, case debrief and "For Our Team" peer support was provided to the specialized staff of Endoscopy.	November 30, 2017
	4. A review and dialogue on the intent of a 'Culture of Safety' and high reliability behavior was conducted by the Peri-Operative leadership with the Peri-Operative staff. The importance of possessing the CHAMP behavior of a questioning attitude was discussed at Peri-Operative staff meetings and safety huddle during the weeks of November 9, 2017 through November 20, 2017.	November 20,2017

	5. Implementation of a "Safety Coach" for Peri-Operative Services ie: OR, Endoscopy, Pain Treatment, Ambulatory Surgery Unit (ASU), Post Anesthesia Care Unit and Nurse Anesthesiology. Onsite training provided by Yale New Haven Health Systems Patient Safety leads occurred on May 1, 2018. 6. The Peri-Operative Nursing Leader and OR educator completed Safety Training at YNHHS Institute of Excellence on April 12, 2018. 7. Unit Based Safety meetings were implement on June 1, 2018.	June 30,2018
	8. Electronic documentation process related to verification of pre-operative/pre-procedure NPO status was reviewed with Ambulatory Care Unit during safety huddles during the week of December 29, 2017. A reference tool was provided to the staff.	December 29, 2017
	Monitoring Plans	
	The manager of ASU will monitor 30 patient files a month x 2months for documentation compliance related to verification of NPO status.	November 1, 2018
	Staff Member by Title Designated for Monitoring of CAP	
	The Manager of Peri-Operative Services was designated to oversee the monitoring of these corrective actions	

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The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing Services (1) and/or (f) Diagnostic and therapeutic facilities and/or (j) General (6) and/or (1) infection control (1).

2. Based on observation, interview, and policy review the facility failed to ensure that the patient positioning gel pads used during operative procedures were without open areas which comprised the surface integrity. The findings include the following:
   a. During tour of the operating room (O.R) department it was identified that OR #7 was recently used, cleaned and in preparation for another case. Two arm positioning gel pads were identified to have open areas on the top and bottom surfaces rendering the pads to be exposed to contaminate and ineffective cleaning. Upon surveyor enquiry it was identified that the gel pads were recently used and cleaned. The O.R. manager identified that the gel pads should not be used if there are torn areas evident, that all staff are responsible for checking the gel pads and that the pads are sent to biomed for repair if damaged. The two pads were removed following surveyor inquiry.

DPH Citation	Measure to Prevent Reoccurrence	Completion Date
2a.	1. Damaged pads noted during room survey inspection were immediately removed and discarded. 2. Replaced pads were ordered and received.	May 30, 2018 June 6, 2018
	3. The Peri-Operative team was educated that the need for visual inspection of OR equipment during room set up includes patient positioning pads. 4. Staff advised that during rounds, they are to visually inspect, immediately remove and repair damaged items when it is appropriate to do so. Staff were advised to remove and repair or discard any item that cannot be repaired.	August 10,2018
	Monitoring Plans	
	1. An audit tool was revised to include the condition of positioning pads. 2. The condition of positioning pads will be monitored bi-weekly x 2 months.	October 31, 2018
	Staff Member by Title Designated for Monitoring of CAP	
	The Manager of Peri-Operative Services was designated to oversee the monitoring of these corrective actions.	